Exploring Options during These Uncertain Times

Presented By

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Blue&Co.

In Partnership With The:

Kentucky Free Health Clinic Association

Kentucky Academy for Family Physicians

Kentucky Rural Health Association

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Ms. Coleman joined Blue in October 2010, and currently serves as Senior Manager in the Lexington, Kentucky office. Ms. Coleman has more than twenty years of healthcare experience with the primary focus on physician related clinics and facilities. This experience includes start-up/development assistance, consulting services, practice assessments, and on-going management and licensure of Urgent Treatment Centers (UTC's), Rural Health Centers (FQRHC's), Community Health Centers (CHC's), Primary Care Centers (PCC's) and For-Profit and Not-For Profit Single and Multi-Specialty groups ranging from one to fifty providers.

Ms. Coleman graduated from Western Kentucky University with a degree in Health Information Management and is a Certified Administrator in Physician Practice Management. After graduation she worked for St. Joseph Hospital in Lexington, Kentucky for five years in Utilization Review and Quality Management and as Manager in the Health Information Management Department. Since then, Ms. Coleman has held positions as Director of Physician Practice Management in the hospital setting and has held multiple Practice Administrator positions. She owned her own consulting firm for ten years prior to joining Blue. Ms. Coleman has assisted several clients in selecting, implementing and training on both Practice Management and Electronic Health Record software products over the last thirteen years.

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OBJECTIVE

Learn the Definition of Rural Health

- ***Learn the basic requirement to participate in the Rural Health (RH) program***
- ***Review regulations of RH licensure***
- ***Review the reimbursement model of the RH program***
- ***Review a sample checklist for RH licensure***

OBJECTIVE Continued

- *Identify what a practice needs to do to evaluate the benefits of participation*
- *Identify process for preparing a facility for licensure*
- *Identify the timeline for licensure*
- *Identify the applications (forms) required for submission*
- *Learn the definition of a Cost Report and when they are to be submitted*
- *Review the benefits of a mock inspection*
- *Review the basic process of the OIG on-site inspection*

Rural Health Licensure

Rural Health Clinic (RHC)

An RHC can be either a for-profit or non-profit entity and is certified and licensed to receive special Medicare and Medicaid reimbursement. RHC are located in either Health Professional Shortage Areas or Medically-underserved areas. Have available a NP, PA, or CNM to furnish services at least 50 percent of the time the RHC operates

For additional information on the operation and services of rural health clinics, visit http://lrc.ky.gov/kar/902/020/145.htm

Benefits

- Special Medicare and Medicaid reimbursement
- Eligible National Health Service Corps (NHSC) participant (to recruit health professionals for underserved areas who in return get loan repayment).
- Eligible for J-1 Visa Waiver Physicians (foreign physicians who stay in US be signing a 3 year contract to serve in an underserved area).
- Auto 10% Medicare incentive payments for Primary Care
- Eligible for federal EMR incentives.

Rural Health Clinic as Defined by Centers for Medicare & Medicaid Services

Rural Health Clinic

An RHC is a facility located in a rural area designated as a shortage area and is neither a rehabilitation agency nor a facility primarily for the care and treatment of mental diseases. A clinic located on an island may be eligible to be certified as an RHC even though it does not have a physician assistant, nurse practitioner, or certified nurse-midwife. (See §6213 of OBRA 1989.)

The State Survey Agency reviews and evaluates the information on the Request to Establish Eligibility, Form CMS-29 and documents submitted with the request, and as necessary consults with the CMS Regional Office (RO) to obtain a determination whether the basic requirements discussed below are met. (The RO will seek the assistance of the Health Resources and Services Administration (HRSA) in this matter.) These requirements are:

Location of Clinic

The clinic must be located in a rural area that is designated as a shortage area.

Medical Direction

The physician(s) providing medical direction must be a member of the clinic's staff or under agreement with the clinic to carry out the responsibilities required of a physician.

Source:http://www.cms.gov/CertificationandComplianc/18_RHCs.asp

RHC Defined – Centers for Medicare & Medicaid Services Continued..

Physician Assistant, Nurse Practitioner, and/or Certified Nurse Midwife Staff

A nurse practitioner, a physician assistant, or certified nurse-midwife must be available to furnish patient care services at least 50 percent of the time the clinic operates. A clinic may request a temporary waiver of these staffing requirements for a one-year period, if it demonstrates that it has been unable to hire a physician assistant, nurse-practitioner, or a certified nurse-midwife in the previous 90-day period.

A subsequent request for a waiver cannot be made less than 6 months after the expiration date of any previous waiver of staffing requirements for the facility.

The Rural Health Clinic Services Act of 1977 (Public Law 95-210) was established to address an inadequate supply of physicians serving Medicare beneficiaries and Medicaid recipients in rural areas and to increase the utilization of non-physician practitioners (NPP) such as nurse practitioners (NP) and an area physician assistants (PA) in rural areas. To qualify as a Rural Health Clinic (RHC), a facility must be in an area determined to be non-urban and designated by the Health Resources and Services Administration as having a shortage of personal health care services or primary medical care services.

Source:http://www.cms.gov/CertificationandComplianc/18_RHCs.asp

Rural Health Clinic Basic Requirements

RHC furnish:

- Physician services;
- Services and supplies incident to the services of a physician;
- NP, PA, Certified nurse midwife (CNM), clinical psychologist (CP), and clinical social worker (CSW) services;

  The NP, PA or CNM must be available to furnish services at least 50 percent of the time the RHC operates.
- Services and supplies incident to the services of a NP, PA, CNM, CP, and CSW;
- Medicare Part B covered drugs that are furnished by and incident to the services of physicians and NPPs of the RHC;

Rural Health Clinic Basic Requirements Continued

RHC's must also:

- Provide visiting nurse services to the homebound in an area where the Centers for Medicare & Medicaid Services (CMS) has certified that there is a shortage of Home Health Agencies;

- Directly furnish onsite routine diagnostic and laboratory services:
  - Chemical examination of urine by stick or tablet method or both;
  - Hemoglobin or hematocrit;
  - Blood sugar;
  - Examination of stool specimens for occult blood;
  - Pregnancy tests; and
  - Primary culturing for transmittal to a certified laboratory;

- Have arrangements with one or more hospitals to furnish medically necessary services that are not available at the RHC;

- Have available drugs and biologicals necessary for treatment of emergency cases;

Rural Health Clinic Basic Requirements Continued

RHC's must also:

- Have a quality assessment and performance improvement program;
- Not be a rehabilitation agency or a facility that is primarily for the treatment of mental disease; and
- Meet other applicable State and Federal requirements.

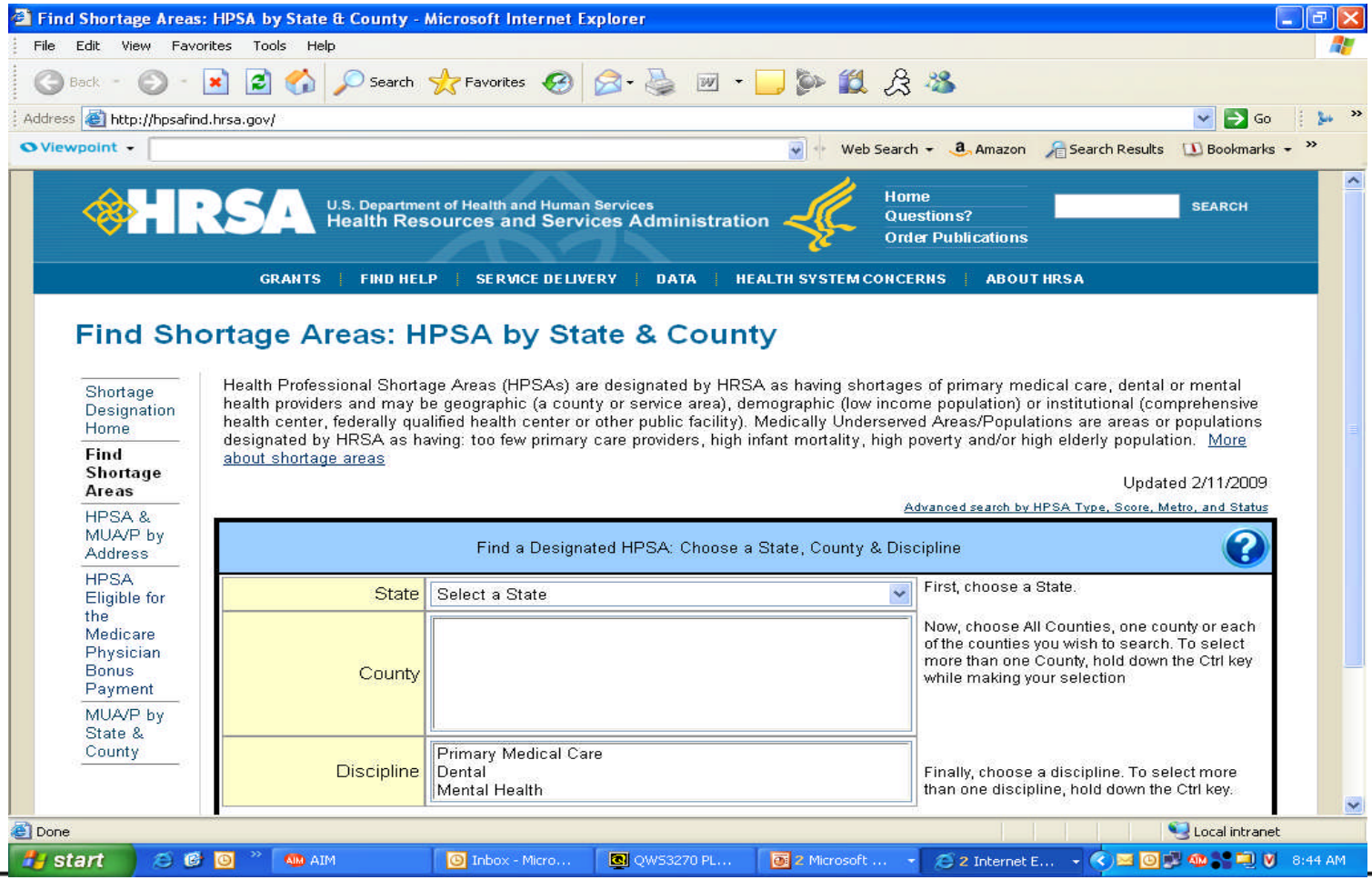
Rural Health Clinic Basic Requirements Continued

To qualify as a RHC, a facility must be located in:

- An area determined to be non-urban, as defined by the U.S. Census Bureau; and
- An area with one of the following current designations:
- Primary Care Geographic Health Professional Shortage Area (HPSA) under Section 443 (a)(1)(A) of the Public Health Service (PHS) Act;
- Primary Care Population-Based HPSA under Section 332(a)(1)(B) of the PHS Act; or
- Governor-designated and Secretary-certified shortage area under Section 6213© of the Omnibus Budget Reconciliation Act of 1989.

HPSA FIND

http://hpsafind.hrsa.gov/HPSASearch.aspx



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IMPORTANT REMINDER!!!

CMS regulations require that the shortages areas used for RHC eligibility must be "UPDATED WITHIN THE CURRENT YEAR OR THE PREVIOUS 3 YEARS."

Sites need to be aware of the most recent date of their designation; this can be found on the following web site http://bhpr.hrsa.gov/shortage

Office of Rural Health Policy is supporting assistance for designations through NARHC

Assistance can also be obtained from the Primary Care Offices in each state by visiting http://bphc.hrsa.gov/osnp/PCODirectory.htm

Rural Health Clinic Payments

- RHC's receive cost-based reimbursement for a defined set of core physician and certain non-physician outpatient services.

- Payment for RHC services furnished to Medicare beneficiaries is made on the basis of an all-inclusive payment methodology, subject to a maximum payment per visit and annual reconciliation.

- The per-visit payment limit to RHC's is established by Congress and is increased each year by the percentage increase in the Medicare Economic Index.

- Payment is made directly to the RHC for covered services.

- Laboratory tests are paid separately.

Cost Reports

At the end of the annual cost reporting period, RHC's submit a report to the Fiscal Intermediary (FI) or A/B Medicare Administrative Contractor (MAC) that includes actual allowable costs and actual visits for RHC services for the reporting period and any other information that may be requested. After reviewing the report, the FI or A/B MAC divides allowable costs by the number of actual visits to determine the final rate for the period.

The FI or A/B MAC determines the total payment due and the amount necessary to reconcile payments made during the period with the total payment due. Both the final rate and the interim rate are subject to screening guidelines for evaluating the reasonableness of the RHC's productivity, payment limit, and mental health treatment limit.

The Rural Health Clinic (RHC) upper payment limit per visit is increased from $78.54 to $79.17 effective January 1, 2013 through December 31, 2013. The 2013 rate reflects a 0.8 percent increase over the 2012 payment limit in accordance with the rate of increase in the Medicare Economic Index (MEI).

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8119.pdf

Cost Reports

Independent RHC's must complete Form CMS-222-92, Independent Rural Health Clinic and Freestanding Federally Qualified Health Center Cost Report, in order to identify all incurred costs applicable to furnishing covered RHC services. Form CMS-222-92 can be found in the Provider Reimbursement Manual–Part 2 (Pub.15-2), Chapter 29, located at **http://www.cms.hhs.gov/Manuals/PBM/list.asp** on the CMS website.

Provider-based RHC's must complete Worksheet M of Form CMS-2552-96, Hospital and Hospital Complex Cost Report, in order to identify all incurred costs applicable to furnishing covered RHC services. A RHC that is based in a hospital with less than 50 beds is not subject to the per-visit payment limit and has an encounter rate that is based on its full reasonable cost.

If a RHC is in its initial reporting period, the all-inclusive visit rate is determined on the basis of a budget the RHC submits. The budget estimates the allowable cost that will be incurred by the RHC during the reporting period and the number of expected visits during the reporting period. Form CMS-2552-96 can be found in the Provider Reimbursement Manual–Part 2 (Pub. 15-2), Chapter 36, which can be found at **http://www.cms.hhs.gov/Manuals/PBM/list.asp** on the CMS website.

Medicaid Cost Reports - http://chfs.ky.gov/dms/rural.htm

Rural Health Clinic Visits (Encounters)

- A RHC visit is defined as a medically necessary face-to-face encounter between the beneficiary and a physician, NP, PA, CNM, CP, or CSW during which a RHC service is furnished. In certain limited situations, a RHC visit may also include a visit by a registered professional nurse or a licensed practical nurse to a homebound beneficiary.

- Encounters at a single location on the same day with more than one health professional and multiple encounters with the same health professional constitute a single visit, except when one of the following conditions exist:

- The beneficiary suffers an illness or injury requiring additional diagnosis or treatment subsequent to the first encounter; or

- The beneficiary has a medical visit AND a CP or CSW visit.

Rural Health Application Process

- Verify HPSA online & verify HPSA date by contacting Steve Salt at HRSA 1-502-564-8955 ext. 3809
- Contract with a Cost Accountant to do a feasibility study (Review the numbers) to assure your facility will benefit from licensure
- Contact Cigna and request an 855 for an initial RHC -Link to pull applications from CMS is: https://www.cms.gov/CMSForms/CMSForms/list.asp#TopOfPage

CIGNA GOVERNMENT SERVICES

PART B PROVIDER ENROLLMENT

1 CAMERON HILL CR STE 0062

CHATTANOOGA,TN,37402-0062

- Complete the Medicare enrollment application & submit (typically 120 day process)
- During this processing period, prepare the site:

  Train staff on Regulations

  Assure all Regulations are met

  Prepare RHC Policies and Procedures

  NOTE: I recommend conducting a Mock Inspection to make sure facility and staff are prepared.

Rural Health Application Process continued

- Request a State Fire Marshall site Inspection 1-502-573-0382
- After the 855 is processed and you receive the letter, submit the OIG application with the fee, three health insurance benefit agreements, two financial solvency forms and State Fire Marshall inspection attached and submit it to the OIG.
- The OIG will verify HPSA eligibility
- The OIG will call the office to verify staffing requirements and hours of operation
- The OIG will forward the application to the field office and request site inspection
- The OIG Inspector will arrive on-site unannounced
- If licensed, the licensure date will be your “effective date”
- If the clinic has deficiencies, the clinic will respond with a plan of correction; the OIG will accept or reject the plan
- Submit Medicare & Medicaid Preliminary Cost Reports
- Submit Medicaid provider enrollment application

NOTE: Rural Health licensure can take 9 -18 months from start to finish

FQHC

Federally Qualified Health Centers **(FQHCs)** are private, not for profit or public entity organizations that:

Receive a grant under Section 330 of the Public Health Service Act. Major advantages of having FQHC designation include:

- Receiving cost based reimbursement for services provided to Medicare patients and cost-derived prospective payment for services provided to Medicaid patients including managed care enrollees;
- Participating in the PHS Act 340B Drug Discount Pricing Program to purchase prescription drugs at steep discounts;
- Access to National Health Service Corp providers and resources
- The right to have out-stationed Medicaid eligibility workers on-site;
- Having access to Federal Vaccine for Children program; and other legal benefits. In addition to the benefits listed above, FQHCs funded under Section 330 also have access to free medical malpractice insurance under the Federal Tort Claims Act (FTCA) program and a myriad of grant and loan opportunities for both service and capital expansions.
- Health centers are also Patient-Centered Medical Homes (PCMH) in that care is delivered in a comprehensive, coordinated way and provided by a health care team. For more info on PCMH, visit http://www.nachc.com/clinicalmedicalhomes.cfm.

FQHC CONTINUED

In order to qualify for Federally Qualified Health Centers **(FQHC)** status, whether receiving Section 330 Grant funding or as a look-Alike, a health center must provide care to either a federally designated Medically Underserved Area (MUA) or Medically Underserved Population.

It is important to note that the health center must serve populations that live in or are designated as medically underserved, but the clinic site does not have to be physically located in the MUA/P. In addition, this requirement is an organization-level one. This means that once any site of the health center meets the criteria, the entire organization is compliant. Opening new sites in other areas does not require additional MUA/P designations. Evaluation –before deciding to proceed you must understand the requirements associated with obtaining health center status (http://bphc.hrsa.gov/policiesregulations/policies/index.html)

- Specifically a health center must be a public or private not-for-profit organization.
- Provide comprehensive, culturally competent, primary care and assure that their patients can access the care regardless of the ability to pay (Sliding Fee Scale).
- Serve a federally designated MUA or MUP.
- Have adequate clinical and administrative leadership, systems and procedures to guide the provision of services and an ongoing quality improvement program.
- Have a community-based board that independently exercises key authorities.

FQHC Continued

The FQHC upper payment limit per visit for urban FQHCs is increased from $126.98 to $128.00 effective January 1, 2013, through December 31, 2013 (i.e., CY 2013), and the maximum Medicare payment limit per visit for rural FQHCs is increased from $109.90 to $110.78 effective January 1, 2013, through December 31, 2013 (i.e. CY 2013). The 2013 FQHC rates reflect a 0.8 percent increase over the 2012 rates in accordance with the rate of increase in the MEI.

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8119.pdf

PRIMARY CARE LICENSURE

Primary Care Center (PCC)

Until February 1, 2013, a licensed Primary Care Center (PCC) also was eligible to receive special Medicaid reimbursement in Kentucky. This reimbursement methodology is based on allowable costs and based on an encounter rate or Prospective Payment System. PCCs must provide basic health care services to patients of all ages, offer a variety of preventive, diagnostic and therapeutic services by a team of a full time MD and a full time RN, or APRN, or PA.

http://www.lrc.state.ky.us/kar/902/020/058.htm

PRIMARY CARE LICENSURE PROCESS

- Contract with a Cost Accountant to do a feasibility study (Review the numbers) to assure your facility will benefit from licensure
- Assure you meet regulations
- Request a State Fire Marshall site Inspection 1-502-573-0382
- Prepare the site:
  - Train staff on Regulations
  - Prepare PCC Policies and Procedures
  - I recommend conducting a Mock Inspection to make sure facility and staff are prepared.
- After the State Fire Marshall Inspection, submit the OIG application with the fee and State Fire Marshall inspection attached and submit it to the OIG.
- The OIG will call the office to verify staffing requirements and hours of operation and that you see patients of all ages
- The OIG will forward the application to the field office and request site inspection
- The OIG Inspector will arrive on-site unannounced
- If licensed, the licensure date will be your “effective date”
- If the clinic has deficiencies, the clinic will respond with a plan of correction; the OIG will accept or reject the plan
- Submit Medicaid Preliminary Cost Reports
- Submit Medicaid provider enrollment application
- Primary Care Licensure can take 6 – 12 months from start to finish

Questions

Blue & Co. – Exploring Options Alternative Models

February 13, 11am EST/10am Central

Physicians CME Credit

Thanks to Kentucky Academy of Family Physicians (KAFP)

1.0 AAFP CME approved credit (equivalent to Cat 1 of the AMA) has been approved for this presentation. Must complete the following survey to obtain credit

https://www.surveymonkey.com/s/4CMEACARHC

Exploring Options during These Uncertain Times - Resources

CENTERS FOR MEDICARE & MEDICAID SERVICES' WEBSITES

CMS Manuals http://www.cms.hhs.gov/Manuals

Critical Access Hospital Center http://www.cms.hhs.gov/center/cah.asp

Federally Qualified Health Centers Center http://www.cms.hhs.gov/center/fqhc.asp

Hospital Center http://www.cms.hhs.gov/center/hospital.asp

HPSA/PSA (Physician Bonuses) http://www.cms.hhs.gov/ hpsapsaphysicianbonuses/01_overview.asp

Medicare Learning Network http://www.cms.hhs.gov/MLNGenInfo

MLN Matters Articles http://www.cms.hhs.gov/MLNMattersArticles

Rural Health Center http://www.cms.hhs.gov/center/rural.asp

Telehealth http://www.cms.hhs.gov/Telehealth

OTHER ORGANIZATIONS' WEBSITES

American Hospital Association Section for Small or Rural Hospitals
http://www.aha.org/aha/key_issues/rural/index.html

Health Resources and Services Administration http://www.hrsa.gov

National Association of Community Health Centers http://www.nachc.org

National Association of Rural Health Clinics http://www.narhc.org

National Rural Health Association http://www.nrharural.org

Rural Assistance Center http://www.raconline.org

U.S. Census Bureau http://www.Census.gov

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THANK YOU

- Kentucky Academy of Family Physicians
- Kentucky Free Health Clinic Association
  - Annual budget $25,000 or less = $25.00
  - Annual budget $25,000-$50,000 = $50.00
  - Annual budget $50,000 or more = $75.00
  - No budget/clinic in formation = $0.00
  - Individual = $50.00

  Contact: Laura Ebert at lebert12@insightbb.com

  http://kyfreeclinics.org/

- Kentucky Rural Health Association
  - $30 Individual Membership
  - Discounted Bundle Memberships available for Agencies.

  http://www.kyrha.org/